

BREAKING BARRIERS IN PROVIDER-PATIENT RELATIONSHIPS:  
AN ANALYSIS OF PERCEIVED INTERCULTURAL COMMUNICATION COMPETENCE  
AMONG NURSING STUDENTS

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Communication can be particularly challenging for community college nursing students during their labor and delivery clinicals as there is an influx of Latino patients at the local medical facilities due to Migrant and Seasonal Farm Workers (MSFWs) arriving for summer work. As a result, the student nurses provide care for Hispanic women and face particular challenges in provider-patient communication during prenatal outreach as well as labor and delivery care due to language and cultural barriers.

The director of nursing at a community college in the Southeastern United States expressed a need for a tool that would assist nursing students to improve their communication with Spanish-speaking patients during labor and delivery clinicals. A website, [nursingcomm.blogspot.com](http://nursingcomm.blogspot.com), was created to assist second-year nursing students with verbal and nonverbal communication and to provide online communication tools to prepare students for communicating with Latina patients in the clinical setting. The goal of this research is to assess nursing students' levels of intercultural communication competence and to analyze their perceptions of the change, if any, they experience in intercultural communication competence after using the website.

Results of this thesis showed evidence that some nursing students' self-perceptions changed after using the website and also that their perceptions of cultural contracts became more co-created. Students demonstrated a higher rate of openness and exhibited the goal of mutually understood communication. Surveys indicated that nursing students using the website more frequently experienced greater improvement in intercultural communication competence than those who used the website less. Implications are offered for future research and nursing student training.



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AMONG NURSING STUDENTS

A Thesis

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Master of Arts in Communication

by

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## DEDICATION

This research is dedicated to my parents, Donald and Virginia Paynter, who always instilled in me the importance of hard work and perseverance and who led me by example to be compassionate to all people, always offering a helping hand whenever possible, and helping provide for the needs of others.

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## **TABLE OF CONTENTS**

CHAPTER ONE: INTRODUCTION	1
Intercultural Communication Competence	1
The Population and Barriers	3
Verbal Communication	9
Nonverbal Communication	11
Cultural Competence Training	17
Why a Website?	20
CHAPTER 2: THEORETICAL APPROACH	23
Cultural Contracts Theory	23
Research Questions	24
CHAPTER 3: METHODOLOGY	26
Sample Selection	26
Self-Administered Questionnaires	29
Self-Administered Interview Surveys	31
CHAPTER 4: ANALYSIS	32
Constant Comparative Method	32
Findings	35
Limitations	44
Conclusion	46
Implications	47
REFERENCES	50
APPENDIX A: THESIS TIMELINE	54

APPENDIX B: PARTICIPANT CONSENT FORM	55
APPENDIX C: INTERCULTURAL COMMUNICATION COMPETENCE SELF-ADMINISTERED PRE-ASSESSMENT	56
APPENDIX D: INTERCULTURAL COMMUNICATION COMPETENCE SELF-ADMINISTERED POST-ASSESSMENT	57
APPENDIX E: INTERCULTURAL COMMUNICATION COMPETENCE SELF-ADMINISTERED PERSONAL INTERVIEW	58
APPENDIX F: DEMOGRAPHICS	59
APPENDIX G: PRE-TEST, POST-TEST AND INTERVIEW CODING	60
APPENDIX H: WEBSITE	65
APPENDIX I: STATE COMMUNITY COLLEGE SYSTEM REQUIRED CURRICULUM FOR CULTURAL TRAINING FOR NURSES	66
APPENDIX J: IRB APPROVAL	69

## **CHAPTER ONE: INTRODUCTION**

### **Intercultural Communication Competence**

The term “intercultural communication competence” has been defined in various ways. A basic dimension of communication competence, according to Wiseman, Hammer and Nishida (1989), is understanding what happens during a communication transaction. This effectiveness of communication involves reducing misunderstandings when applied to an intercultural context (Wiseman, et. al., 1989). Another quality of communication competence is the perceived judgment made by individuals during an interaction (Wiseman, et. al., 1989). As people from different cultures communicate, interpersonal challenges can surface because of differences that exist between the two cultures. This often results in misunderstanding by both parties involved and can lead to a negative opinion of one or both parties. Understanding the other culture and the people within that culture can help improve cross-cultural communication (Wiseman, et. al., 1989). This understanding of the other culture includes being familiar with their language, values, ideology and beliefs. For this study, the term “intercultural communication competence” refers to an understanding of another person’s cultural background and the application of that understanding in intercultural communication (Wiseman, et. al., 1989).

Healthcare providers must be able to effectively communicate with diverse audiences. Sometimes this means changing the way one communicates with an audience depending on their cultural background. Cultural competence begins with the first encounter during the office visit. In 2000, the Office of Minority Health established official cultural and linguistic competence standards noting the importance of providers’ cultural awareness, knowledge, skills and inductive learning (Chong, 2002).

Research shows one of the best ways of promoting health among Latinos is to improve

patient/provider communication (Elder, Ayala, Parra-Medina and Talavera, 2009). The way nursing students communicate with patients during clinical rotations can directly impact the care the patients receive. However, like many nursing students, the community college nursing students in this study receive only basic communication training (Taylor, Lillis, LeMone, Lynn, 2010). To engage in intercultural communication competence, nursing students must be open to new information and ideas and know that others' perspectives may differ from their own.

The website, Intercultural Communication in Nursing, originated following my conversation with the director of the nursing program regarding the complexity of communicating with Latina patients who speak a different language and come from a different culture. The director noted the difficulty students have trying to communicate effectively when neither the student nor the patient speaks the others' language.

The website includes information relevant to intercultural communication, with cultural background information, along with tips for communicating verbally and nonverbally with Latinas. Students from a different nursing cohort than in this study provided information to me about what they would like to communicate to and glean from their patients. I compiled that information and worked with a translator to construct interpretations from English to Spanish. (Throughout this paper, the terms “Latino” and “Hispanic” are used interchangeably in keeping with the original sources of information. The term “Latina” refers to Hispanic females.)

After using the website, community college nursing students should be able to:

- Identify ways to better communicate with patients from different cultures;
- Communicate relevant information during labor and delivery to Spanish-speaking patients;
- Identify and overcome barriers and communication challenges when communicating with people of different cultures;
- Understand that different audiences communicate differently nonverbally;
- Understand how to build a rapport with a Latino patient or audience;
- Better communicate with patients through nonverbal communication;

- Understand that what works for the sender is not always what works best for the receiver.

By improving these intercultural communication tactics, nursing students can optimize communication with Hispanic patients, and hopefully improve patient care.

### **The Population and Barriers**

Experts estimate that approximately 20 percent of 3.5 million Migrant and Seasonal Farm Workers (MSFW) in the United States are women (Colt, Stallones, Cameron, Dosemeci and Zahm, 2001). Nearly 95 percent of MSFWs are from Mexico and speak Spanish as their native language (Mehta, et. al., 2005). On average, most have completed sixth grade and 20 percent are illiterate in Spanish (Mehta, et. al., 2000). This section provides an overview of known factors affecting Latinas' general health and health during labor and delivery. These challenges can contribute to a lack of healthcare access, decline in personal health practices and poor health outcomes.

Hispanic residents come to live in the state where the research was done in three ways. Some are born here. Some move from other states and some move directly from Mexico and other Latin American countries (Office of Minority Health, 2010). Forty-seven percent of the Hispanics here were born in the state and 53 percent are foreign-born (Office of Minority Health, 2010). Of the foreign-born Hispanics who live here, 70 percent are of Mexican origin and 17 percent have Central American backgrounds (Office of Minority Health, 2010). Fifty percent of foreign-born Hispanics entered the United States after 1999; 36 percent entered in the 1990s, and 14 percent entered prior to 1990 (Office of Minority Health, 2010). Although county statistics do not offer a population dataset by geographic origin beyond the "Hispanic or Latino" classification, a county health department patient educator (K. Lowry, personal communication,

June 4, 2013) shared that many seem to be from Mexico. The remaining seem to be from Honduras, Guatemala, El Salvador, Columbia and Venezuela, according to a translator at the local hospital (A. Solorzano, personal communication, June 6, 2013). These projections are consistent with state statistics.

### *Existing Health Risks & Disparities*

Pregnant MSFWs are at higher risk than expectant mothers from other cultures for spontaneous abortion, premature delivery, fetal malformation, growth retardation and abnormal postnatal development (Hanson & Donohoe, 2003). MSFW infant mortality is estimated to be twice as high as the United States national average (Slesinger, Christenson, Cautley, 1986). One in 28 infants is born to a mother who began prenatal care in the third trimester or did not have any prenatal care (Martin, Hamilton, Sutton, Ventura, Menacker, and Munson, 2005). In the state, 30.5 percent of Hispanic mothers report not receiving any prenatal care until after the first trimester or not receiving that care at all (Office of Minority Health, 2010).

In a 2010 study of 150 Mexican women working in California's Central Valley fields, 80 percent reported they had been sexually harassed (Waugh, 2010). Sexual harassment can precipitate the development of posttraumatic stress disorder (Hogan, 2011). For some women, the symptoms of posttraumatic stress disorder (PTSD) are quite persistent and may or may not be recognized immediately (Hogan, 2011). The presence of PTSD can possibly contribute to a lack of prenatal care (Hogan, 2011) which could result in problems during pregnancy.

Another study found 52 percent of MSFW women monitored had less than recommended weight gain throughout their pregnancies (Centers for Disease Control and Prevention, 1997). The same study reports 23.8 percent of women surveyed had undesirable birth outcomes, 6.7 percent had low birth weight, nearly 10 percent delivered preterm and 6.5 percent of infants were

small for their gestational age (Centers for Disease Control and Prevention, 1997). Infants with low birth weight can be at higher risk for many health related issues including infection, perinatal morbidity, delayed motor and social skill development and learning disabilities (Centers for Disease Control and Prevention, 2012).

One study examining the diet of MSFWs reported 61.2 percent have deficiencies in Vitamin A consumption (Thomas, 1996). Vitamin A is critical for formation and development of cells and tissues and plays an important role in the healthy development of fetal lung development (Strobel, Tinz, Biesalski, 2007). Healthcare providers recommend pregnant mothers increase vitamin A intake by 40 percent and breastfeeding mothers increase vitamin A intake by 90 percent (Strobel, et. al., 2007).

According to a 2007 study of MSFWs, 82 percent of households experienced food insecurity and 49 percent reported hunger (Weigel, Armijos, Hall, Ramirez, Orozco, 2007). According to the United States Department of Agriculture (2013), food insecurity refers to a family's experience of reduced food intake, at least periodically, and their disrupted normal eating habits due to lack of money or resources for getting food.

This lack of access does not only apply to food insecurity but also to health insurance. In a Migrant and Seasonal Farmworker study by the National Center for Farmworker Health, Inc. (2009), only 8 percent of farmworkers reported being covered by employer-provided health insurance. The rate dropped to 5 percent for farmworkers who were employed only seasonally (National Center for Farmworker Health, Inc., 2009). All of the aforementioned disparities can negatively impact the labor and delivery experience for MSFWs.

### Barriers to Healthcare Access

Low income, lack of insurance and lack of transportation can be barriers to healthcare



access. The majority of MSFWs and their families have incomes considered below federal poverty levels with half of all farmworker families earning less than \$10,000 annually and with half of individual farmworkers earning less than \$7,500 per year (Mehta, et. al., 2000). Although as a population Latinos are the most employed minority in America, they are the least insured minority population (Chong, 2002). In a survey by the Office of Minority Health (2010), nearly 30 percent of Hispanic mothers reported they could not see a doctor for prenatal care due to cost and 65 percent reported having no health insurance. Additionally, Hispanics reported substantially higher percentages than Caucasians or African-Americans for not having a personal physician (Office of Minority Health, 2010). MSFWs often lack transportation and vacation time and have language barriers. Since many are illiterate even in Spanish, they may be unaware of the existence of and need for prenatal care and accessible healthcare options. They may not be aware healthcare during pregnancy can help avoid problems with the baby or child later.

In speaking with an interpreter who works at the community college and the local hospital, I learned Latina patients often do not trust interpreters. For example, during an interview, the translator (A. Solorzano, personal communication, June 6, 2013) said patients even distrust a Spanish-speaking interpreter like herself at times. She said sometimes they tell her she speaks differently from them and they question her and comment that she is not like them. They tell her they want to know who she is. It takes a couple of years to gain their trust if trust is established at all. This is due to the variance of vernacular and accent among Spanish-speaking cultures by region.

From all of this information about MSFWs, it is clear that numerous barriers exist to their accessing healthcare and making healthy lifestyle choices in general. Moreover, those Latinas preparing for labor and delivery may have special needs in order to have a healthy baby and to

remain healthy themselves. Even though the work of MSFWs is critical to the United States economy, they are still some of the most underserved people in the United States (Hanson & Donohoe, 2003).

### Understanding the Culture

Culture plays an important role in communication crucial to understanding interactions involving MSFWs and, more specifically, with Latinas expecting a child. Chong (2002) explains Latino cultural values and how their daily practices are different from what many other Americans are used to. She describes Latinos as preferring collectivism, familialism and personalismo. Latinos come from a collectivist culture, meaning they prefer the company of other people and value group needs over individual wants and desires (Ting-Toomey and Chung, 2012). They may find strength and a sense of belonging (and even their sense of self identity) in relationships (Chong, 2002). Further, Latino nuclear and extended families tend to be closely knit with the expectation that members treat each other with respect, loyalty, and unity (Chong, 2002). Personalismo refers to the ability to relate to others on a personal level, despite socioeconomic standing or other differences. Gender also plays a role in communicating with Latinos. The man is generally the center of the social life, and the woman is the center of the care for the family and home. This is frequently called Machismo. The Latino culture also views time as more flexible and laid back than many other Americans. Their culture's perception of time is often classified as polychronic, meaning they participate in many activities at once and are very involved with people (Barkai, n.d.) rather than having set times for activities and values of punctuality and timeliness. Therefore, healthcare providers should understand that Latino's conceptualizations of time could lead to longer appointments or missed appointments. Additionally, Latino patients may use an indirect communication style and may appear to be

passive even when facing serious health issues (Chong, 2002). In other words, they may respond to a direct question with an indirect answer.

As with any patients, Latinos' values play a role in how they view health and illness. Many factors including religion, education, age, acculturation and belief in alternative medicine should be considered by their healthcare providers. For example, the perceived level of severity of an illness by a Latino patient along with variations in education level may impact when and from whom the patient seeks care. Latinos of all educational levels are known to seek care from folk healers such as botanists and herbalists when the prognosis is bad (Chong, 2002). They also rely on self-care such as self-medication and home remedies over outside (traditional) medical care when the illness is not severe (Chong, 2002). Latinos may see United States healthcare as hostile and many times will seek folk healing over traditional medical care (Chong, 2002). Additionally, although Hispanic patients have respect for modern medicine and its benefits, they may combine religion and traditional healing in forming their definition of health (National Alliance for Hispanic Health, 2000). Therefore, providers should exhibit respect and understanding when treating and communicating with Hispanic patients (National Alliance for Hispanic Health, 2000).

It may be challenging to obtain a Latino patient's clinical history for a few reasons. First, they tend to be less direct and they sometimes provide much more information than needed from the perspective of the healthcare provider (Chong, 2002). They often contribute the needed information only when asked (Chong, 2002). Due to the predominance of paternalistic views, Latinos may feel it is the provider's responsibility to find out what is wrong (Chong, 2002). Also, they may suppress information as a result of fear of severe illness (Chong, 2002). That is, they may not want to know about severe illness: not knowing is considered culturally consistent

with the belief that health is not necessarily an individual's responsibility (Chong, 2002). The provider should LISTEN by considering Language, Illness, Subject, Touch, Educational Level and Norms of the culture (Chong, 2002).

Many of the diseases affecting the Latino population in America are the same as those impacting others in America. In fact, Chong (2002) says Latinos who are less acculturated, or have been in the United States the least amount of time, are generally more healthy than those who are more acculturated. The longer Latinos are here, the more unhealthy they become. This can be attributed to a couple of factors. First, their access to healthcare usually becomes more limited once they move to the United States. Second, they begin to practice more Americanized eating habits – such as eating readily available fast foods known to be less healthy than prepared foods (Chong, 2002). A study by Jeffery, Baxter, McGuire, and Linde (2006) in the United States, for example, showed a correlation between higher frequencies of eating at fast food restaurants and higher weight and less healthy eating habits.

### **Verbal Communication**

Verbal communication is difficult during labor and delivery clinicals as the community college nursing students provide care for many Hispanic women who do not speak English. It is difficult for the English-speaking nursing students to communicate with the Spanish-speaking patients without knowing the language.

Effective verbal communication requires good listening skills and paying attention to patients' nonverbal cues, including body language (Samovar, Porter, McDaniel, Roy, 2013). Hispanics prefer indirect tactics in language (Chong, 2002). For example, they put off asking direct questions and many times offer indirect responses (Chong, 2002). This can be different from many American patients who show up to an appointment with a list of questions in hand

(Chong, 2002). Hispanics also value interpersonal relationships and resist confrontation, choosing instead to set their own concerns aside in order to maintain harmony (Samovar, et. al., 2013). As the United States becomes more globalized (and this change impacts healthcare settings), it is important we understand cultural differences impact our abilities to communicate competently with those from different cultural backgrounds (Samovar, et. al., 2013).

Translators aid in intercultural verbal communication between healthcare providers and patients. For effective and accurate translation, a translator should be fluent in both languages and should be able to convey health-related messages including medical terminology in both languages (Management Sciences for Health, 2012). Further, they need to offer proper translation, providing context without including their own opinions or beliefs (Management Sciences for Health, 2012). The use of a patient's relatives or friends for translation is not recommended (Management Sciences for Health, 2012). Relatives and friends may modify the patient's words. Moreover, depending on family and friends as translators may violate Title VI of the Civil Rights Act of 1964. Title VI and related regulations guarantee English as a Second Language (ESL) patients the language assistance needed to ensure “meaningful access” to health and social services received through federal funding (Management Sciences for Health, 2012).

Verbal communication allows nurses and patients to interact exchanging useful information in the healthcare setting. When considered in an intercultural context, verbal communication can be challenging. Verbal communication is a way of exchanging information and ideas orally including attitudes, beliefs and values. In intercultural communication situations, one cannot separate language and culture because language is the channel by which we communicate and adapt to our own cultural system. That is, language enables us to form our cultural identities and cultural expectations as well as the rules for interaction. Language is also

culturally based. Word choice reflects the attitudes, values and beliefs of one's particular culture, and in some cases, a cultural group may have idiosyncratic language not known or recognized by other groups.

So, although knowing the language the patient speaks helps in communicating, it is not the only necessary skill. As an example, one interpreter explained that she has experienced non-Spanish speaking providers building better rapport with Spanish-speaking patients because of their strong nonverbal communication skills (A. Solorzano, personal communication, June 6, 2013). Overall, understanding appropriate nonverbal communication is necessary for working with Latina patients. Merely knowing the Spanish language is not enough.

### **Nonverbal Communication**

Nearly two-thirds of meaning in face-to-face interaction is transferred nonverbally (Elder, et. al., 2009). Therefore, providers must realize communication is more than a verbal exchange. One of the best ways of promoting health among Latinos is to improve effective provider-patient communication nonverbally (Elder, et. al., 2009) such as using nonverbals that recognize the primacy of relationships to Latinos. When a provider seeks to understand a patient's culture and incorporates their understanding into his or her care, better patient outcomes are more likely. Knowing the cultural expectations detailed below might help improve provider-patient communication.

Nonverbal communication includes any nonlinguistic messages sent and received whether intentionally or unintentionally through proximity, kinesics, haptics, oculosics, time and tone and volume. These messages communicate one's attitudes, emotions, status, and relationships. In order to produce shared understanding, both the sender and receiver should understand the nonverbal cues of the message (Cruz, 2001). Nonverbal communication is used

within patient-provider dyads whether we realize it or not. This occurs as people express themselves nonverbally without being aware they do so. Provider nonverbal communication can affect patient adherence to medical advice and as a result impact recovery, wellness and survival. Many times, because a patient is nervous or fearful, provider nonverbal communication is crucial. Positive and effective communication within the patient/provider dyad is linked to greater mutual liking, rapport and trust (Ambady and Rosenthal, 1998).

Understanding nonverbal cues is also critical in order for providers to know if patients understand what they are saying, to see if patients are interested, and much more. Nonverbal cues can have very different meanings from culture to culture (Diversity Council, 2008). In the healthcare setting, especially in intercultural interpersonal interactions, the sender and receiver too often misinterpret nonverbal cues.

Most people assume their nonverbal cues are like those others use. William Cruz (2001) calls this assumed similarity in nonverbal communication “projected similarity.” Projected similarity can set up inappropriate assumptions about nonverbals. Further, there can be frequent misperceptions and misunderstandings in intercultural nonverbal communication because people do not consider other perspectives and norms about communication (Cruz, 2001). In order to effectively treat any community or culture of people, healthcare providers must be knowledgeable about the cultural values, differences and behaviors of the communities and individuals they serve (Vivanco, 2008).

### Familialism

Since Hispanic patients are more likely to involve family members in their treatment and decision-making, it is important to accommodate patients and family members at their comfort level whenever possible. In the Hispanic culture, the patient may not be the only communicator

when describing symptoms, selecting treatment options, or carrying through with a recommended treatment. Providers should determine the patriarch and matriarch and take notice when acculturated children or non-family are the spokespeople (National Alliance for Hispanic Health, 2000). Furthermore, a provider might allow several family members or friends to be involved in a consultation, if the patient so chooses, to make the patient more comfortable and to be more culturally sensitive.

### *Voice Tone*

When a provider greets a Latino patient, special consideration should be given to the appropriate cultural use of nonverbal cues. Voice tone should not be too loud or too soft. Gender roles and titles should be used correctly. Direct, probing diagnostic questions are most effective but directness can also be misinterpreted as the provider's desire to end the visit so discretion is needed (Chong, 2002). The volume and tone used during verbal communication speak nearly as loud as the words used. Tone and speech volume can tell receivers if a communicator is shy, enthusiastic or afraid. White Americans often perceive higher speech volume as meaning a person is angry. For Latinos, raised voices may represent excitement (Diversity Council, 2008) instead.

### *Eye Contact*

The study of eye contact in interpersonal communication is called oculosics. Americans generally look into the eyes of the person with whom they communicate. This differs from Latinos because although they make eye contact with the person with whom they are communicating, it is in a more indirect or fleeting way. For example, they may look into the eyes and then look away while still speaking. This could be misinterpreted by a non-Latino provider as lack of truthfulness or certainty (Cruz, 2001). Eye contact, facial expressions, gestures and



touch should be carefully considered when communicating with Latino patients during the office visit. The interpretation of such communication can impact their response to the provider as well as to the recommended treatment (Chong, 2002).

Latinos may also show respect nonverbally by avoiding eye contact with those in authority. Healthcare providers should not misinterpret this as disinterest or lack of paying attention. To reciprocate respectfulness when addressing older Latinos, healthcare providers should look below their eye level. This is especially important if the provider is younger than the patient. When interviewing Latinos, communicators should keep in mind their characteristic nonverbal expressions rather than interpreting them as a lack of self-confidence. With the Latino cultures, prolonged eye contact can be seen as a challenging, can represent anger, or can represent romantic interest. So, if a provider ignores these nonverbal cultural characteristics when providing care for a Latino, the patient may feel very uncomfortable and be less compliant (Cruz, 2001). Hispanic patients may also terminate treatment if they do not perceive they are being respected (National Alliance for Hispanic Health, 2000).

### Personal Space

Proximity, or preferred personal space, for most Americans is between 18 and 33 inches. For Latinos, preferred proximity for personal space is smaller, between eight to 18 inches. As a result, when Latinos and other Americans interact, the Latino may feel the American is too distant and may move closer to adjust to their culturally established comfort level (Cruz, 2001). It may be necessary for an American provider to move closer in space to a Latino patient to be respectful. When providers distance themselves from Latino patients by more than two feet, they may be seen as distant and uninterested (National Alliance for Hispanic Health, 2000) even though the provider may be quite comfortable. Providers can also allow Latino patients to

establish their own distance at the beginning of the office visit. Further, providers may practice increased cultural competence by sitting closer, leaning in or by expressing other cues showing support of the patient and their culture (National Alliance for Hispanic Health, 2000).

### *Body Language*

Kinesics, or the study of body movement and facial expressions, is a type of nonverbal communication. Many times, Latinos replace verbal communication with a smile. For example, a person may smile instead of greeting someone. Therefore, in the healthcare setting, American providers may receive a smile instead of a verbal response such as “Thank you.” To Latinos, expressing appreciation verbally may come across as impersonal (Cruz, 2001). Some Latinos use unique facial expressions that do not exist in American culture. If a person shrugs with their palms facing upward a Latino person may receive the gesture as vulgar (Management Sciences for Health, 2012). Latinos may point with their lips puckered to symbolize the verbal expression: “there” or “over there” or “him” or “her.” This expression may resemble the American’s blowing a kiss and therefore could be misinterpreted. Latino men may also greet other men by jerking their head up and back (Cruz, 2001).

### *Touch*

Haptics, or the study of touch, is another consideration in the study of nonverbal communication. When greeting one another, it is common for Latino women to greet female friends with a kiss on the cheek or a hug as an expression of “hello.” Likewise, they commonly touch the other person on the arm while connecting verbally. For Latino men, it is common to share hugs with other men, shake each other’s hands, touch the other’s arm, or to place their hand on the other’s shoulder when communicating man to man (Cruz, 2001). Latino men may also greet each other with a strong handshake (Diversity Council, 2008).

In a healthcare setting, an American provider may misinterpret these expressions as a Latino patient being pushy or may be uncomfortable with the communication experience. If a provider responds negatively to such a misinterpretation of the patient's expression, the patient may feel the provider is disinterested, insulted, or uncomfortable (Cruz, 2001). Therefore, when working with Latino patients, nurses may wish to incorporate casual touch when speaking to patients.

### Time

When it comes to time, Latino patients may care more about the present situation than what is to come. When providers interact with Latino patients, they may focus more on immediate solutions or treatment paths than long-term goals in order to be culturally respectful. Latinos are also more casual timekeepers and have a reputation for being late. When possible, this should be taken into account when flexible appointment schedules are available (Vivanco, 2008).

The Management Sciences for Health "Provider's Guide to Quality and Culture" website offers the following tips for providers to effectively communicate with patients through appropriate nonverbal cues: let the patient set the tone; respond to the patient's nonverbal cues; use caution when interpreting expressions; and do not force a patient to follow certain nonverbal behaviors (Management Sciences for Health, 2012). Cultures and traditions change over time and no communicator will ever know what nonverbal behaviors are most preferred by every culture. It is important for providers to pay attention to patients and take notice of how they react to provider communication.

## **Cultural Competence Training**

The idea of cultural knowledge includes the process of learning about the language, worldview and other perspectives of cultural differences (Almutairi, et. al., 2014). The term “cultural competency” is a general concept, broad in scope, which characterizes communication interventions with the purpose of improving access and effectiveness of healthcare services to people in racial and ethnic minority groups (Truong, Paradies, Priest, 2014). The study of cultural competency developed mainly as a result of the reality that cultural and linguistic barriers in patient-provider communication can affect healthcare quality and delivery (Truong, et. al., 2014). International literature regarding cultural competency is prevalent (Truong, et. al., 2014). But, the majority of what is available in the United States related to the topic of cultural competency integration in healthcare is merely what is required by regulatory agencies (Truong, et. al., 2014).

In a study identifying cross-cultural communication issues observed by medical interpreters, three main areas were identified where communication difficulties were prevalent between physicians and patients: perceptions of the patient’s health issue, expectations during the clinical interaction and verbal and nonverbal communication (Hudelson, 2005). For example, interpreters shared examples of how verbal and nonverbal communication can have a different meaning for patients and providers (Hudelson, 2005). In one scenario, a doctor attempted to encourage a female patient to follow his recommended treatment, but inadvertently used a gesture insulting to the patient (Hudelson, 2005). The patient described the gesture as a sexual insult when the provider intended to imply for the patient to get moving (Hudelson, 2005), an example of projected similarity.

Medical questioning styles can also be foreign and incomprehensible to patients, and

patient responses are many times interpreted by physicians as illogical or incoherent (Hudelson, 2005). Patients can even be reluctant to participate in open communication when a provider appears to have little knowledge of their culture (Hudelson, 2005). It is important for a provider to show interest in the patient's culture to establish rapport (Hudelson, 2005). Lack of awareness of cultural differences and the communication issues that can result are at the foundation of the problems patients and providers face in intercultural communication (Hudelson, 2005).

Several agencies provide standards for culturally competent healthcare for use in training healthcare providers such as nurses (Cueller, et. al., 2008). Initiatives by these agencies highlight the need for improved cultural competence education in undergraduate nursing education (Cueller, et. al., 2008). The need for nurses to understand demographic changes in healthcare in the United States has never been greater (Cueller, et. al., 2008). Although healthcare providers as a whole acknowledge the need for culture-specific education, implementation has been weak (Cueller, et. al., 2008).

The goal of producing nurses who possess cultural competence should begin with education at the student nurse level (Long, 2012). Since the 1980s accrediting bodies and approval boards for nursing practice have required teaching of cultural competence (Long, 2012). Two widely used resources in crafting cultural competence concepts during curriculum development are the Office of Minority Health's "Culturally Competent Nursing Modules" and the United States Department of Health Resources and Services Administration's "Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education" (Long, 2012). Although cultural competence has been defined through texts and literature, the deployment of intercultural communication competence training has been left as the responsibility of individual nursing schools (Long, 2012).

Many disparities in healthcare can be addressed through education, but nursing educators' cultural competence is critical in reaching the goal (Long, 2012). Several studies evaluated the attitude, preparation and skills for teaching cultural competence (Long, 2012). One study of nursing educators revealed nearly 100 percent of the nursing faculty was teaching cultural competence; however, only 53 percent actually remembered learning about it during their studies (Long, 2012). This implies almost half of nursing faculty were teaching cultural competence with little preparation for application (Long, 2012). Therefore, many of today's nursing students could be receiving cultural competence training from instructors not qualified to teach it, or perhaps the pedagogical methods being used are simply not working.

Clinical interactions with real experiences can increase student comfort and confidence level when providing care to patients from diverse backgrounds (Long, 2012). This comfort and confidence has been shown to increase with repeated exposure to patients from different cultures (Long, 2012). Programs focusing on skills and strategies needed for cultural competence during a clinical interaction, or learning specific cultural norms about a different culture, can produce positive attitude changes in nursing students (Long, 2012). In order to deliver patient-focused care, acquiring knowledge and personal experience regarding a culture's attitudes, belief systems, values and common behavior is necessary (Long, 2012). Nurses are in better positions to assess patient needs and facilitate unique cultural sensitivity because they spend more time with the patient than other healthcare employees (Ume-Nwagbo, 2012).

Presently, the state community college system only requires 12 hours of what they refer to as cultural training. According to the director of nursing, the state mandated, required coursework includes separate units in the NUR 111 Introduction to Health Concepts course covering Diversity, Culture, and Spirituality. (See Appendix I for a complete outline.) Per the

state community college system requirements, approximately 12 hours of class time are utilized to cover the Diversity, Culture and Spirituality content (C. Traish, personal communication, October 1, 2014). The content outlined in the requirements is general and does not refer to specific cultures. Instead, it requires instruction on the basic definitions of diversity, culture and spirituality to show these ideals can differ across cultures. The mandated coursework does not include any culturally specific topics or norms. The director of nursing indicated that at the community college where the sample attends, cultural competence is incorporated into instruction as applicable. However, on a broad scale it can be assumed community college students in this state system do not receive a pre-established, mandated culturally-specific curriculum or training in order to communicate best with the geo-varying cross-cultural populations they may serve.

At the community college where the sample is enrolled, the director of nursing explained that they teach a “womb to tomb” concept based curriculum (C. Traish, personal communication, October 1, 2014). In other words, cultural training is incorporated as they study specific subjects including: cardiac, pulmonary, reproduction and more. Hypothetically, she said, instructors teach students during class time and in clinicals how culture plays into patient care in specific areas of healthcare (C. Traish, personal communication, October 1, 2014). However, there is no mandated guideline or curriculum provided for this type of culture-specific training.

### **Why a Website?**

This section explores the effectiveness of delivering information to nursing students via a website. The study seeks to learn about students’ perceptions of how the website impacted their perceived intercultural communication competence when working with Latino patients.

To do this, students were asked to review the website throughout the semester as they

worked in clinicals. They provided feedback regarding their perception of the site's effectiveness in delivering information helpful in improving their intercultural communication competence.

A website was selected as the delivery medium for sharing intercultural communication competence information with the nursing students for several reasons. First, student schedules and information usage were important concerns when considering pedagogical strategies combined with technology (Perry and Pilati, 2011). Perry and Pilati (2011) found flexibility in use and limits on the need to be on campus were two of the features most attractive to students when considering online learning (Perry and Pilati, 2011). Online offerings specifically allow students to work around employment and family obligations and other endeavors (Perry and Pilati, 2011). Finally, the use of a website is highly accessible. A website allows students access to tools via mobile devices during clinical situations, as well from home or from the classroom.

#### *Knowledge and Behavior Change*

Stout, Villegas, and Kim (2001) argue knowledge can lead to behavior change. One way to facilitate converting knowledge into action is to allow people to rehearse the new behavior in a safe setting (Stout, et. al, 2001). A website can offer a platform where users can practice new behaviors, test their knowledge and ultimately perform in the real world setting with a higher level of efficacy leading to higher success (Stout, et. al, 2001). The website for the nursing students allowed them to discuss what they learned with their peers and instructors, to rehearse by using the online quiz and other tools, to review and test their knowledge and practice it by implementing what they learned in the clinical setting.

#### *Benefits of Web-based Learning*

Web-based learning can allow students to accommodate varying schedules. In most cases, web-based information sharing is learner-centered and easily modified and expanded.



Web-based information also facilitates assessment and promotes self-directed learning (Cook and Dupras, 2004). According to Cook, et. al. (2004), web-based learning may not be superior to traditional methods, but its advantages make it suitable for supplementing and/or replacing courses in many circumstances. The design for web-based learning should include more than simply assembling a nice website; it should promote active learning, motivation and evaluation (Cook, et. al., 2004).

### *Reasons for Choosing Web-based Learning for the Nursing Students*

Other media, such as printed materials, were originally considered as tools to use in educating the students about communicating interculturally with Latina patients. For example, during initial conversations, the director suggested a pocket guide or flip chart would provide content in English for the students and in Spanish for the patients. Using that approach, patients and students could communicate together by reading the same labor and delivery information in each of their respective native languages. However, as noted within this document, many MSFWs are illiterate in their native language. Along with research supporting the effectiveness of website use for teaching and learning, I chose to produce a website during the summer of 2012 as the main learning tool.

Renate Motschnig-Pitrik (2005) says educators contend significant learning should include the whole person: their intellect, skills, and feelings. Further, Motschnig-Pitrik (2005) argues student-centered learning becomes significant personally as processes integrate new knowledge, elements and insights into existing understandings so the learner moves to an advanced level of meaning. Consequently, a website that could be updated based upon feedback seemed to be most suitable.

## **CHAPTER TWO: THEORETICAL APPROACH**

### **Cultural Contracts Theory**

Cultural Contracts Theory provides the theoretical basis for my research. The theory was developed in 1999, by Dr. Ronald Jackson, a cinema and media professor and identity scholar (Drummond and Orbe 2010; Jackson, 2002). Importantly, the theory describes a process for cultural identity by considering gains, losses and exchanges of one's ability to interpret his or her own view of the world (Drummond, et. al., 2010). First, the theory asserts affirmation through communication is needed to develop identities (Drummond, et. al., 2010). Second, a constant exchange of identities occurs making the process dynamic. Third, identity contracts are established (Drummond, et. al., 2010) between communicators.

The theory assumes intercultural interactions may be coordinated or not, depending on dynamics like power, boundaries, cultural loyalty, maturity and group identification (Drummond, et. al., 2010). The Cultural Contracts Theory also asserts human experience is partially defined by relationship coordination grounded in assimilation, adaptation and/or the valuation of each individual (Drummond, et. al., 2010). This coordination with others comes only after an initial negotiation is settled by one's self (Jackson, 2002) where the individual develops the meaning of his/her own identity. When a person carries an ascribed racial identity, the identity takes on importance for the person, a negotiation process sometimes occurring quickly and subconsciously (Jackson, 2002). Intrapersonal adjustments can then be made to accept, reject, or compromise parts of an individual's worldview.

According to Jackson and Stewart (n.d.), when identity negotiation takes place, it is assumed that cultural differences cause cultural conflict. Identity negotiation, then, refers to when a person mindfully and consciously shifts from his or her own worldview or cultural

behavior to accommodate another's. As an individual's negotiated identity is brought to relationships with others, differences between people can then become apparent (Jackson, 2002).

### **Research Questions**

As Wiseman, et. al. (1989) suggest in their Predictors of Intercultural Communication Competence, knowledge of another person's culture can determine one's ability to reduce misunderstandings in intercultural communication. With this in mind, my first research question asked: (RQ1) *How did nursing students' self-perceptions of their own provider-patient cultural contracts change after utilizing the website?*

Individuals should be able to successfully communicate in a mutually acceptable way during cross-cultural interaction. Each culture has its own expectations for what communication is considered culturally appropriate and effective (Gudykunst, 2005). Effective communication requires listening and paying attention to the other person in an interaction.

Humans often bring both highly attached and immovable identities into interactions (Jackson, 2002). Still, individual identities can change throughout a dialogue or interaction (Jackson, 2002). People take their identities with them into each and every communication, including those interactions with other cultural groups. From birth, our identities and how we see ourselves, form in part by others and continue to shape as we interact with others. We let other people define norms and we establish implicit and explicit "contracts" with others dictating how we progress in relationships (Jackson, 2002).

Even though in-depth information about verbal and nonverbal communication with Latinas was offered on the website for the nursing students, I did not know at onset how the information might influence actual interactions with their patients. This leads me to my second research question: (RQ2) *How did the website content influence the nursing students' clinical*

*experience, if at all?*

*Ready-to-sign, Quasi-completed and Co-created Contracts*

According to Cultural Contracts Theory, every intercultural relationship exhibits a contract, which can be ready-to-sign, quasi-completed or co-created (Drummond, et. al., 2010). The figurative term “contract” refers to negotiation and agreed upon terms of relationships, rather than to a written agreement. A ready-to-sign contract is a prenegotiated cultural agreement promoting assimilation and maintaining the status quo (Drummond, et. al., 2010). This type of contract is generally used by people unwilling to look beyond their own worldview (Drummond, et. al., 2010). The quasi-completed contract is a cultural agreement that is partially pre-negotiated and only somewhat open to negotiation (Drummond, et. al., 2010). This type of contract is usually demonstrated by someone willing to negotiate a little but wanting to maintain his or her own worldview. The co-created cultural agreement is fully negotiable with only personal preferences and requirements as limitations (Drummond, et. al., 2010). This type of contract is used by individuals highly willing to change their worldview based on experiences with other people.

### **CHAPTER THREE: METHODOLOGY**

This research was interpretive and exploratory in nature utilizing qualitative data analyses. Using Cultural Contracts Theory, I hoped to determine if a relationship would exist between exposure to a website as an intercultural communication learning resource and perceived improvements in intercultural communication competence by the nursing students. Using student answers to survey and interview questions, I sought to identify which phase(s) of contract negotiation (i.e. ready-to-sign, quasi-completed, and co-created) each student was in - both before and after exposure to the website.

As the students used the website and its tools, they provided feedback to ensure any necessary adjustments would be made to the website in the future. However, no changes were made during the research. The website will remain live and accessible to future students when the research period ends. I plan to maintain a dialogue with the director, instructors and students to find out where my research and website efforts best suit their clinical needs in the future.

#### **Sample Selection**

The study used a nonprobability sampling approach to research a subset of a population to see if the audience was affected by exposure to a website containing intercultural communication information about the target audience. The research results using this approach could suggest a relationship between this group and the population but do not necessarily indicate a correlation (Baxter and Babbie, 2004). Further, convenience sampling was used to secure a segment of the population for study rather than choosing a random sample (Baxter and Babbie, 2004).

I drew conclusions about the nursing students being studied but took special care not to generalize or assume all nursing students would act or perform similarly to my findings. For

instance, I recognized the conclusions drawn would not necessarily correlate with the way all community college nursing students might respond given the same circumstances.

### *Sample for This Study*

My study focused on second-year nursing students at a community college in the Southeastern United States. The study sample included the entire second year cohort beginning in the Summer Semester 2014. The sample included 27 second-year nursing students at the community college. These students provided a fresh perspective on the subject of study because they did not have much clinical experience and did not have much experience navigating cultural contracts in intercultural communication with patients such as Latinos. Student participation in the study was voluntary. Full disclosure of the purpose of the study was given in writing before research began. Before administering the first survey, students were briefed and given the opportunity to review the consent form, ask questions and sign the consent form.

### *Demographics*

The student nurse sample ranged from 20 years old to 53 years old with an average age of 29 years old. Ninety-six percent of the sample self-reported as female, and four percent male. When asked to describe their cultural background and given the opportunity for open-ended response: 15 described themselves as Caucasian, three as African-American, one as Puerto Rican and African-American, one as Puerto Rican and Caucasian and two as Native American. Five students did not provide any information describing their ethnic origin. In addition to providing their ethnicity, forty percent identified as Christian. This indicated many students identified their religion as an important part of their cultural background. When reporting educational level, sixty-six percent of the sample reported having “some college, no degree;” seven percent had an Associate’s degree; twenty-two percent had a Bachelor’s degree and three percent had a Master’s

degree.

The group was selected based on feedback from the director of nursing, the timing of their clinical studies and the increase of interactions with Latina patients during that time. The students in the sample are in a cohort scheduled to graduate from the nursing program in May 2015.

#### Overview: Approach Used in the Study and Rationale

Computerized self-administered questionnaires offer flexibility for students to respond on their own schedule, at their own pace, to a variety of questions. Furthermore, this type of metric limits the amount of interviewer bias and offers an option of anonymous response (Baxter and Babbie, 2004). Clear instructions were provided and open-ended questions were carefully crafted to avoid the use of vague and unfamiliar language. Participants were asked to respond to the questionnaire accessed via direct URL. (Additional information about the ways the survey/questionnaires were used is detailed below.)

In addition to self-administered surveys, standardized interview surveys were given where I personally interviewed the participants all at one time, allowing them to record their own responses on individual computers in the classroom. During the interviews, students were encouraged to share stories and explain processes, problems and solutions, again without limitation of length. Twenty-three students within the sample responded to the interview survey.

Standardized interview surveys generally provide higher response rates than self-administered surveys (Baxter and Babbie, 2004). Similarly, respondents are more likely to provide thorough responses when a researcher asks questions in person. Interviewers can also explain questions if needed (Baxter and Babbie, 2004). Another advantage is personal interviews allow the researcher to observe nonverbal responses. Questions with open-ended answers can

prevent interviewer bias. For example, when respondents are required to make a selection from pre-formulated responses, they may be forced to answer in a way inconsistent with their feelings.

### **Self-Administered Questionnaires**

To examine how the students' self-perceptions of their provider-patient cultural contracts changed as a result of utilizing the website, computerized questionnaires were self-administered before and after they used the website. Data from these questionnaires were used to answer the first research question (RQ1). The results of both surveys were analyzed for themes and coded accordingly for comparison as explained in more detail below.

Constant Contact, an online system, was used to deliver the questionnaires. The students entered their own responses via a web browser connection. They were allowed to use class time or personal time to complete the survey electronically, but all chose to complete during the allotted class time. The questionnaires included seven questions such as: Do you have clearly defined terms for communicating with Latino patients? Are you flexible when communicating with Latino patients? Approximately how many times have you used the website?

The first of two electronic questionnaires was given to the entire sample at the beginning of the cohort's summer 2014 semester before exposure to the website containing intercultural communication information. The goal of the first questionnaire, the "pre-test," was to provide a baseline qualitative assessment of how students self-described their attitudes, feelings and beliefs towards navigating intercultural communication with Latino patients in the clinic. The first data set was collected in the first two weeks of the Summer 2014 semester on May 28, 2014 and was compiled electronically via the Constant Contact system and exported into a comma-delimited Microsoft Excel file for future review and analysis. The entire sample of 27 nursing students participated in the pre-test.



The second of two electronic questionnaires, the “post-test,” was given to the entire sample on Monday, July 28, 2014, just after the students’ final exam, following exposure to the website and intercultural communication information throughout the Summer 2014 semester. The goal of the second questionnaire was to examine the impact of the website and exposure to intercultural communication information through the change in how the students self-describe their attitudes, feelings and beliefs towards navigating intercultural communication with Latino patients in the clinic. Constant Contact again provided an online medium where nearly identical survey questions were asked. Students were allowed to use class time or personal time to complete questionnaires electronically, and all students chose to complete the survey during class. The second questionnaire data set was compiled electronically as a comma-delimited Microsoft Excel file for final review and analysis. Twenty-three students within the sample responded to the post-test.

Prior to answering each questionnaire, students were provided an introductory statement explaining the purpose of the research, how data would be shared and their involvement in the study. This information also explained they were not required to participate in the research and could opt out of the study at any time. Following receipt of the information, they consented to their participation by continuing on with the study. The students were asked for their thoughts and ideas in responses to the surveys without regards to any boundaries or right or wrong answers. They were allowed to include responses of any length, as short or as long as they desired.

To encourage participation in the questionnaires, I briefed the students before the questionnaires were offered, explaining the importance of their participation as a way to improve their intercultural communication and overall intercultural competence. Furthermore, class time

was provided for the students to complete the questionnaires. I observed as they entered their responses. By observing the students, I could see they were engaged in the questionnaire, and focused on providing responses. Had I not attended, they may have rushed through their responses or not taken the questionnaire as seriously.

### **Self-Administered Interview Surveys**

Interviews were held in the students' classroom during their scheduled class on the community college campus. During the interviews, I asked participants the following three questions: Tell me a story about a significant intercultural experience during your clinical rotation. How did your previous experiences help you with this? Did the website content help you in this situation? Before the interview began, the participants were briefed to ensure their understanding of the terms of the study.

The goal of the interviews was to examine how the students perceived the website content was or was not helpful to them as they navigated intercultural communication during their clinical experiences. Data collected included descriptions of interactions with patients without disclosure of identifying patient information. The interview results were analyzed to answer the second research question (RQ2).

## **CHAPTER FOUR: ANALYSIS**

Data collected via Constant Contact during the pre-test, post-test and interviews was exported into Microsoft Excel spreadsheets for thorough review. To begin, I read through each response looking for keywords and phrases to help identify the expectations, pre-conceived ideas and goals each student had regarding interactions. This process is referred to as “coding” (Kolb, 2012). To decide what seemed important to the students, I looked for repeated use, and similarities between responses.

### **Constant Comparative Method**

I used a qualitative form of analysis, the Constant Comparative Method, to inductively draw conclusions from the collected data. This process uncovered and verified information through a systematic collection and analysis of data (Strauss and Corbin, 1990). This approach allowed me to begin by studying intercultural communication competence among nursing students, and to see what emerged from my research (Strauss and Corbin, 1990). I analyzed the data, drawing conclusions through discovery and development using the Constant Comparative Method.

This method blends process, reduction, explanation and theory (Lindlof, 1995). First, I determined categories and compared instances in each category (Lindlof, 1995). The categories were formed as common themes emerged among participant responses. Also referred to as “labels” or “concepts,” the categories were formed by breaking down observations, sentences and/or paragraphs and defining what they stood for (Strauss and Corbin, 1990). To do this, I asked questions about what the data represented, and compared similar data that could be given the same name (Strauss and Corbin, 1990).

Next, I developed new categories, and constantly compared each one to others already

formed, thinking in terms of relationships among categories, dimensions and conditions (Lindlof, 1995). As I completed these steps, ideas emerged that I could build on and clarify, gradually refining each category (Lindlof, 1995). Korb (2012) describes data reduction as a process occurring throughout a study that simplifies and transforms raw data. Data reduction also pieces sections and parts of information into categories (Kolb, 2012).

### Levels of Analysis During Coding

Three levels of analysis were conducted in the coding process: open coding, axial coding and selective coding (Kolb, 2012). First, I began with general coding, or open coding, by thoroughly reading through the data, thinking critically to compare responses (Kolb, 2012). Combing through the responses, I circled recurring words, and responses that were both similar and different to other responses. As Kolb (2012) suggests, I continually asked questions about the content I understood, and what I did not understand, identifying common themes, different properties and traits in the data, and grouping content into like categories (Kolb, 2012). As I went through the data, I marked the text and made notes for reference as I made connections. Without the first stage of coding, the remaining analysis could not take place (Strauss and Corbin, 1990). While completing open coding, I systematically analyzed every response to the fullest extent, breaking it apart and dissecting content (Kolb, 2012). The open coding resulted in a collection of words and phrases used to describe students' perceptions and thoughts. (Refer to Appendix G for charts demonstrating coding methods.)

Next, axial coding led me to piece the data together in ways I had not pursued during the first phase of analysis. I continued to ask questions, seek answers, and make connections. The inductive and deductive process of thinking about the data in categories and new subcategories was key to the axial stage of the coding exercise (Kolb, 2012). Here, I made connections

between concepts and themes uncovered during the open coding. This level of coding allowed me to sort the words, ideas and phrases from the open coding, in a non-hierarchical manner, to result in categories of common themes. For example, open coding such as “They do not know English.” and “I do not know Spanish.” or “Translator needed” were categorized as “language barriers” during the axial coding exercise. (See Appendix G for examples of axial coding.)

Finally, selective coding provided a means of identifying and choosing final categories, or themes (Kolb, 2012). Through categorizing, asking questions, and establishing core categories, I validated traits, similarities and differences among the responses the nursing students provided (Kolb, 2012). The core categories were themes most frequently appearing within the data. As these categories emerged, I made notes on a separate page, and recorded all related information relevant to each category. This process allowed me to look at all angles of each category based on what I knew about the research, the timing of the survey and the students. I began to realize the students not only described their perceptions of future interactions as difficult, but also based these ideas on interactions they had not previously encountered. (Appendix G outlines the selective coding chart.)

#### Unexpected Changes in Sample

It should be noted some students in the original sample who answered the pre-test survey questions were unable to participate in the post-test and interview survey due to work schedules and other demands. Also, nearly half of the students expressed they had not participated in communication with Hispanic patients during the study, but they shared their perceptions of how the cultural information on the website might help them in future interactions. These unanticipated changes were acknowledged, but I continued to follow the overall methodological approach noted above in order to answer my research questions.

## Findings

The pre-test and post-test were used to answer the first research question (*RQ1: How did nursing students' self-perceptions of their own provider-patient cultural contracts change after utilizing the website?*). The results of both surveys were analyzed for themes and coded accordingly for comparison as noted in the analysis section. In the pre-test survey prior to exposure to the intercultural communication learning tool, the website, the students made statements explaining their perceptions as outlined below. The students were asked to use pseudonyms to ensure anonymity.

### Anticipated Difficulty

Difficulty was undoubtedly the dominant theme present in the pre-test survey data. Even before entering into the clinical setting, the majority of students expressed anticipated difficulty with impending interactions with Hispanic patients. Most students shared they had not worked in intercultural dyadic relationships within the healthcare setting; however, they consistently described they expected interactions with Hispanic patients to be “difficult.” In fact, 44 percent of the sample used the word “difficult” or “difficulty” when explaining what they anticipated the intercultural patient-provider interactions to be like. Those who did not use the descriptor often used words like “language barrier” and “cultural differences” in outlining how they perceived impending interactions to be. None of the students indicated anticipated ease in communication with Hispanic patients.

The sample largely expressed self-doubt due to not knowing the patient's language, and due to their lack of confidence in patient communication as a result of the patient not understanding English. The difficulty was most often defined by the respondents as communication presenting language barriers and cultural differences. The following excerpts

represent some of the student feedback received:

- Liliana Grey: “I expect some difficulty in communication due to language barriers and cultural differences.
- Tonton: “I do not speak their language so it would most likely be difficult.”
- Neal: “I am sure it will be difficult to communicate with them.”
- Nursejhf2015: “Difficult since I have had little spanish [sic] since high school.”
- Diamond: “I expect it to be a communication barrier, because they would not understand me and I would not understand them.”

The post-test survey data, which showed respondents’ perceptions following exposure to the website, was consistent with pre-test data where respondents explained interactions as “difficult.” However, after learning about intercultural communication with Hispanic patients via the material provided on the website, the occurrence of the word “difficult” decreased, only being used by 29 percent of participants. Their reasons for the anticipated difficulty, although less frequent, were consistent with their explanations in the pre-test referring to difficulty resulting from language barriers, cultural differences, and lack of mutual understanding.

After explaining the intercultural interactions as difficult during the post-test, many students included follow-up statements where they: 1) better identified what can make intercultural communication difficult, 2) explained how intercultural patient-provider communication was easier than before they used the website, and 3) acknowledged that better communication is possible with increased cultural knowledge and understanding. For example, the following phrases were recorded in the post-test survey responses:

- SamJo: “I think that using the website will help me with my future interactions with Latino patients.”
- Tonton: “I expect to be confident and able to understand more about Latino patients and how to communicate with them.”
- Beth: “I think it will be challeging [sic] but with the help of others and resources like nursingcomm.blogspot [sic] it should be easier.”

The post-test data showed an improvement in the perceived level of difficulty when many individuals described intercultural interactions as a learning experience, saying the website would help them in their intercultural communication, they looked forward to applying the knowledge they had learned, they expected the barriers to be lessened, and their communication would be better than before.

The participants also explained how they might apply what they learned from the website in future intercultural communication citing specific examples such as: “I will smile and avoid prolonged eye contact.” This information was most likely gleaned from the website’s reference to cultural preferences in nonverbal communication. In their responses, several individuals provided ways they could implement what they learned from the website in order to better communicate and demonstrated improved cultural competence saying they might focus more on culturally accepted nonverbal cues such as smiling and avoiding prolonged eye contact with Latinos. The students indicated through these responses that they had reviewed the content on the website and perceived it as helpful when applying it in intercultural interactions to improve communication and cultural understanding.

### *Language Interventions*

In the pre-test and post-test, students painted a picture of both anticipated and experienced intercultural communication encounters, highlighting the presence of language barriers. For example, in the pre-test, statements such as: “They do not know English.” and “I do not know Spanish.” were often made by the nursing students to explain such barriers. Many students explained in the pre-test that their knowledge of the Spanish language was very limited. Conversely, they described language interventions like the use of translators as being helpful to improving and eliminating language barriers.



Before and after utilizing the website, many of the participants indicated the need for linguistic interventions such as the use of a translator, family member who knew English, and/or devices such as MARTI, a device used by the local hospital to provide interpreters via video. They also expressed the need to learn Spanish and for their patients to learn English. Responses pre and post exposure to the site were consistent, suggesting the desire of most students to have these interventions in place.

During the final interview, some respondents emphasized the responsibility of someone else to provide translation services. For example, one student described a past clinical experience, explaining how helpful it was for a mother's teenage son to translate for the mother. As the student went on to share more about the scenario, the student shared the mother was being treated for vaginal bleeding due to an ectopic pregnancy and lost a child as a result of the complications. The student provided this as an example of a helpful language intervention (to have the son as a translator) but did not acknowledge any concern with having a child translate about a topic they most likely did not understand for a relative during such a sensitive time. Respondents also provided examples using of notecards with pictures other healthcare providers utilized in communicating with Hispanic patients. These language interventions were characterized as helpful.

The students' responses regarding language interventions demonstrated a basic understanding of the types of aids available. However, they did not understand when and how such interventions should be used. This was apparent when they described situations involving family members providing translation. Additionally, participants explained how patients did not know their language more often than they referred to themselves as not knowing the patients' language. Along with the responses described above, I believe while the nursing students felt the

language barrier should be addressed, they did not necessarily believe the responsibility was for them to provide the intervention, but rather for them to use outside resources.

### *Cultural Contracts*

Drummond, et. al. (2010) explain cultural contracts as occurring in three categories. Such categories are not linear and do not occur each occur in an interaction. A ready-to-sign contract is a pre-negotiated cultural agreement that promotes assimilation and maintains the status quo (Drummond, et. al., 2010). This type of contract is generally used by people who are unwilling to look beyond their own worldview (Drummond, et. al., 2010). The quasi-completed contract is a cultural agreement that is partially pre-negotiated and only somewhat open to negotiation (Drummond, et. al., 2010). This type of contract is usually demonstrated by someone who is willing to negotiate a little but wants to maintain his or her own worldview. The co-created cultural agreement is fully negotiable with only personal preferences and requirements as limitations (Drummond, et. al., 2010).

During the post-test survey, the students were asked to select the option best describing how they felt about intercultural interactions. They were given three choices with the option to select one. These multiple choices were developed in alignment with the aforementioned three stages of the Cultural Contracts Theory:

- A. Pre-negotiated - You are not going to change what you say or do during an interaction based on someone else's cultural background,
- B. Partly Pre-negotiated - You are on the fence and might consider altering the way you communicate to accommodate the expectations of the person from another culture,
- C. Fully Negotiable - You are going to do your best to communicate with a person of another culture the way you understand they want to be communicated with.

One hundred percent of the students selected “Fully Negotiable,” which directly correlates with the students perceiving intercultural dyads as a cultural agreement with the only

limitations being personal preferences and requirements. Drummond, et. al. (2010) define this stage as “co-created.” Although the students unanimously self-identified such interactions as being co-created, their pre and post-test survey responses outlined in this section conveyed their contracts are, in fact, largely predefined.

Post-test responses demonstrate apparent shifts in the nurses’ self-perceptions regarding contracts and could imply cultural contracts may become more negotiable or co-created following the use of the website. This was evident as their responses shifted from describing anticipated interactions as difficult due to cultural and language differences during the pre-test to explaining in the post-test how interactions would be less difficult and how they could apply new knowledge to lessen communication barriers following their use of the website.

When asked in the post-test survey what they expected it to be like when interacting with Latino patients, they described the interaction as less of a challenge than when they responded to the same question in the pre-test. For example, some students said:

- NavyBrat: “Just like every other interaction with other patients. Maybe some communication problems due to language differences.”
- TonTon: “I expect to be confident and able to understand more about Latino patients and how to communicate with them.”
- SamJo: “I think that using the website will help me with my future interactions with Latino patients. I believe that the cultural difference will make things a little more difficult but better than before.”
- Layne: “I found that interacting with the Latino patients I had was very hard sometimes, but after using this website I was better able to communicate and understand the Latino.”
- Candy: “I expect the communication barrier to be lessened now that I know ways to effective ways to communicate with a Latino.”

Additionally, such statements as outlined above provide affirmation of the first research question (*RQ1*), explaining ways where these changes in self-perceived cultural contracts occurred after exposure to the website. One student, Layne, summarized in a post-test response: “After using this website I was better able to communicate and understand the Latino patients I

came into contact with especially at the Health Department this semester for school.” Another student, Ann, stated how she would apply what she learned from the website during future interactions: “When I interact with Latino patients I expect it to be somewhat difficult, but I feel with the use of appropriate facial expressions, touch, and gestures, it can be somewhat simple.”

### *Mutual Understanding*

In both surveys, the nursing students as a whole indicated their desire for mutual understanding when working with Hispanic patients. They revealed good communication is needed in order to meet patient needs, to build trust, to have mutual understanding, and to ensure patients are comfortable. Using responses like “I want to make sure they understand,” students expressed their goal of understanding as a common theme throughout the data collection. During the pre-test, when asked what their goals were when communicating with Latino patients, 71 percent described their main goal as being able to understand the patient, for the patient to understand them, and/or for mutual understanding. In the post-test, when asked the same question, 84 percent of the respondents defined their goal as mutual understanding. Examples of this type of language include, Skibumnit: “Making sure that they understand what I am trying to convey to them” or Tonton: “My goals would be to make sure every patients’ needs are met without communication barriers standing in the way.” This supports the second research question (RQ2) showing a higher rate of openness and an increase of students exhibiting the goal of mutually understood communication.

Several participants said they would “do their best” to establish trust and patient rapport by seeking to understand cultural differences, understanding patient needs and wants, letting patients know they are listening, and paying attention to their nonverbal communication. They expressed this through statements like the following: (Maverick) “It will always be a

challenging experience when being confronted with an unknown language or cultural background. I personally would smile, avoid prolonged eye contact and be clear, concise and as complete as possible with my patients.” Or Tonton: “I expect to be confident and able to understand more about Latino patients and how to communicate with them.” Although the students outlined how they could participate in helping ensure mutual understanding, they still identified patient responsibility saying they would like for the patient to be open to learning, to try to understand, and to express their understanding.

### Website as a Learning Tool

The data obtained during the interviews also confirmed the second research question. When interviewed, students who experienced interactions with Hispanic patients shared positive feedback regarding the usefulness of the site and effectiveness of the content saying:

- Morgan: “I believe this website gave good tips and advice on ways to effectively communicate with patients who speak a different language.”
- Ann: “I remembered reading on the website about Hispanic women and their preferences.”
- Sierra Chamblee: “... afterwards I visited the website to look over some things I could've done or said differently to enhance the experience and I learned some helpful information.”
- Layne: “Yes it helped me because I felt better prepared when I had to deal with the Hispanics patients in our community.”
- Nurse 13: “I was able to communicate through the son, however, by knowing cultural cues and proper body language, I was able to still have a good relationship when communicating to the mother.”

Based on their individual time spent on the website as reported in the post-test survey, it may be deduced that nurses who used the website more experienced more improved perceptions of intercultural communication competence than those who used the website less. The students who spent a longer amount of time on the site discussed their subsequent intercultural patient experiences as a “learning experience” and said (SamJo) “I think that using the website will help

me with my future interactions with Latino patients.” They also shared thoughts like: (SamJo) “I believe that the cultural difference will make things a little more difficult but better than before.”

There is no question from this research that any amount of exposure to cultural competence training can be helpful in communication. Based on these results, it might also be inferred that time spent learning about other cultures is directly correlated to the level of competence in communicating with those cultures.

### Interviews

During the interviews, I asked three questions.

1. Tell me a story about a significant intercultural experience during your clinical rotation.
2. How did your previous experiences help you with this?
3. Did the website content help you in this situation?

While answering the questions, students were reminded to reflect on their clinical interactions during the summer semester. The interviews were intended to provide additional insight regarding the students’ experiences, in an open-ended, non-scripted format. By asking open-ended questions, the students were able to share what they felt was most important about their experiences without that being researcher-defined.

During the interviews, I also asked respondents to share specific stories of any significant intercultural experience(s) they had during their clinical rotation. They were asked to share how previous experiences helped with the interaction, and if the website content helped them specifically during the situation.

Nearly half of the participants disclosed in the interview they had not interacted with Hispanic patients following use of the website due to limited time in the clinic and limited exposure to patients. However, even though they could not directly explain how the site benefited them due to lack of interactions, they still shared details regarding how they expected

the information could help them during future interactions. Sentiments like the following were recorded:

- SamJo: “I think that if i [sic] were to have one the website would have been helpful in letting me know how to react to certain things with the patient. Also in how my culture is different and how to adapt my care to be more beneficial for them.”
- TonTon: “I think the content had some good information and I believe it would have been helpful with communicating but I did not get to apply it during this clinical rotation.”
- Denise: “I will find it useful in the future when I am able to interact with someone from another culture.”

Final coding, or selective coding, of the interview data revealed following exposure to the site content, some students still explained it was the patient’s or someone else’s responsibility to know the language and/or to have good verbal communication, or to provide linguistic support such as translation. At times, they discussed the importance of having a translator. Examples such as a patient’s teenage son, MARTI and a medical interpreter were used.

The final coding also showed the students had a perceived comfort following exposure to the website with cultural information. Their reflections on their experiences provided affirmation for the second research question (*RQ2*) stating that the website and cultural information would be helpful in intercultural interactions. Additionally, they indicated the website helped in interactions with patients by giving them confidence, making them comfortable, and helping them understand. The nursing students said the site and cultural information gave them a very good base knowledge on how to help Hispanic patients and delivered good facts and information. They suggested a site like this one should provide information about other cultures as well. (This suggestion is discussed further in the implications section.)

### **Limitations**

Computerized self-administered questionnaires provide benefits, but there are also inherent weaknesses or limitations to using these questionnaires. First, because the

questionnaires were self-administered, the researcher relied solely on the respondent's interpretation of the questions. Second, bias could have been present as artificiality can surface. Artificiality occurs when participants feel they need to take an opinion on a topic just because they are asked about it (Baxter and Babbie, 2004). To help prevent artificiality, none of the questions required a response.

Another limitation to consider is that respondents may not complete self-administered questionnaires or may not provide a thorough response with useful information. For this reason, I shared with them the importance of the research and its possible implications to improved patient care and better health outcomes. I believe they provided useful responses because of their genuine desire to help patients through accurate and relevant research on the topic of intercultural communication. Their feedback told me the students possess an overall interest in positively affecting patient outcomes.

A final limitation was the inability to correlate responses in a linear fashion to see how specific students' perceptions changed throughout the study. Unfortunately, even though I recorded student-selected pseudonyms and made those available to the students during each phase of the research, some of them used multiple pseudonyms throughout the study. Also, five students who participated in the pre and post-test surveys did not participate in the final interview due to work schedules and other obligations. Therefore, a line-by-line comparison was not feasible.

Social desirability could be considered another limitation to this study. These students have chosen to serve others through their nursing care. They could have angled their responses toward socially acceptable positions on intercultural interactions. This could have influenced their decision to define their interactions as mutually agreed upon, or co-created.



Though all of these possible limitations are worth consideration, it should also be noted the students voluntarily participated in the study. They knew their answers were anonymous, and they took the time to provide thought-provoking responses. The feedback they shared correlates with their experiences, and there is no reason to believe their answers did not represent their true opinions and perceptions. Special care was taken early in the study and throughout data collection to clearly avoid any form of coercion to get students to participate in the study.

### **Conclusion**

Cuellar, Brennan, Vito, and de Leon Siantz (2008) say cultural competence encompasses systems, agencies, and healthcare providers who possess the ability to address the unique needs of diverse populations, specifically those populations different from the mainstream American culture. They posit:

Globalization, immigration, the rapidly growing culturally diverse populations, and the changing ways of healthcare delivery have established the critical need for a curriculum that incorporates culturally competent nursing throughout the educational process.

However, evidence does not yet exist regarding the best way to educate culturally competent nurses. (Cuellar, et. al., 2008, p. 144)

Additional research would provide better insight as to the best pedagogical approach for teaching cultural competence to nursing students.

Furthermore, although healthcare employees and agencies have identified the need for culturally specific care, it does not occur often (Cuellar, et. al., 2008). Integrating intercultural competence education in the nursing field is not optional (Cuellar, et. al., 2008) but must become more of a priority in today's healthcare fields.

This study concludes undergraduate nursing students with limited exposure to cultural

training showed a perceived improvement in intercultural communication competence and increased confidence in interacting with patients who are culturally diverse. They saw interactions as less difficult after learning about the culture. The students approached intercultural interactions with greater ease and confidence and an attitude of eagerness to solve communication issues after exposure to the website.

Intercultural communication competence in patient-provider relationships seems to be another understudied topic. It has been my aim in both the development of the website and subsequent research to bring to light the issues Hispanic patients face and to train a portion of the next generation of nurses to address the communication and health needs of their audience. This research is both relevant and timeless. The basic principles outlined can be applied to most any intercultural interaction. More could be done during nursing training and within the healthcare field to better assess, acknowledge and understand the needs of culturally diverse patients.

This research also shows how with a basic understanding of the other culture, student nurses can learn to communicate with patients who are different from them. Through knowledge of the population they serve, nursing students can enjoy improved cultural competence and can proactively work toward mutual understanding when working with patients.

In order to improve communication, the first step for community college nursing students is to learn more about their audience and become more culturally competent. To assist them with this, I researched the MSFW culture and shared the findings on the student website. My belief is that the students' intercultural communication improved over time, and will positively impact patient-provider rapport and patient health outcomes, and the healthcare industry and quality of care is improved overall.

## **Implications**

This research has great implications for the future of undergraduate nurse training, especially in the community colleges during clinical rotations. The findings demonstrate an obvious need for increased cultural training for healthcare workers. Not only is the need present, but the study suggests positive changes can result from intercultural training.

This research only addressed one prevalent minority: Hispanic patients. However, some of the same principles and strategies could be applied across other cultures to train healthcare providers. For example, increased knowledge of other cultures could lead to more informed care thereby enabling providers to treat the whole patient based on the patient's cultural norms.

In the future, I recommend more collaboration between trained medical interpreters and healthcare providers in the clinical environment. Trained medical interpreters offer bilingual and many times bicultural dimensions in patient-provider communication (Hudelson, 2005). Their depth of experience in intercultural communication in the healthcare setting can provide a broader lens into the complexity of patient-provider communication problems (Hudelson, 2005). Because of the vital role they play in understanding and liaising between multiple cultures, more involvement in training healthcare workers to provide culturally competent care would be beneficial (Hudelson, 2005). Data suggests even a short amount of time invested in a meeting between a provider and interpreter can result in heightened awareness of communication and cultural differences and lead to improved intercultural communication (Hudelson, 2005). Hudelson (2005) noted medical interpreters' voices are surprisingly not represented in existing research.

With the diverse populations nurses in the southeast United States now serve, I highly recommend the state-mandated community college nursing curriculum be enhanced to include

intercultural communication competence training. Rather than merely teaching future nurses that differences in diversity, culture and spirituality exist, they must be taught how to handle those differences with diverse populations. Information that increases intercultural communication should represent various minority cultures with more emphasis placed on audiences specific to each region.

Many patients represent minority groups providers may not be skilled to treat due to the cultural expectations and norms that exist. In order to adequately provide the level of care necessary in preventing disease, maintaining health, and treating conditions, it is absolutely imperative that healthcare employees at all levels receive culturally-specific intercultural communication training. Therefore, the future of the field of healthcare and patient outcomes are dependent on how providers address the needs of their patients.

Intercultural communication competence efforts not only impact healthcare professionals and patient outcomes among individuals and communities, but it also impacts the quality of life for us all. By helping provide for the needs of individuals who come from other cultural backgrounds, by meeting them where they are when possible, we can embrace our differences, drawing on those same differences to help us understand humanity. Furthermore, it is inevitable that our world has changed and continues to change. Therefore, it is necessary for us to learn how to communicate with people from various backgrounds. Finally, intercultural competence and compassion translate beyond cultural differences and help us understand individuals who differ from ourselves. Understanding these differences and embracing them as opportunities for learning experiences can also help us better understand ourselves and achieve our goals in life as we make our way through this multicultural world.

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## APPENDIX A: THESIS TIMELINE

### Fall 2013

- Committee selected
- Proposal prepared

### Spring 2014

- January 7: First Proposal Presentation to Committee
- Revised Proposal, defined methodology
- April 2: Second Proposal Presentation to Committee
- Obtained Committee Approval for Proposal
- Began working draft of Institutional Review Board document
- Submitted research to Institutional Review Board (deadline April 15<sup>th</sup>)

### First Summer Session 2014

- Meet with director of nursing and instructor to introduce research, ask questions and answer questions.
- Meet with nursing students to introduce research and explain consent.
- Administer Pre-test questionnaire.
- Synthesize, analyze data.
- May 19: ECU First Summer Session begins
- May 28: Community College participants begin Summer Semester classes
- June 24: ECU First Summer Session ends

### Second Summer Session 2014

- June 25: ECU Second Summer Session begins
- Took thesis hours
- Scheduled interviews.
- Administered Post-test questionnaire.
- Synthesized, analyzed data.
- July 28: Held interview
- Began analyzing interview responses
- July 30: Community College participants completed Summer Semester classes
- July 31: ECU Second Summer Session ended

### Fall 2014

- Took thesis hours
- Continued analyzing data
- Applied for graduation
- Scheduled defense date for Fall 2014 for October 15
- Finalized thesis
- Distributed thesis draft to committee four weeks prior to defense
- Distributed final copy of thesis two weeks prior to defense
- October: Defended and made any necessary revisions
- November/December: Submitted revised thesis to the University
- December 2: Deadline to submit thesis to graduate school
- December: Graduation

## APPENDIX B: PARTICIPANT CONSENT FORM

My name is Kelley Paynter Deal. I am conducting research for my Master's in Communication at East Carolina University. I also work here at the college as the senior director of marketing and communication.

As a second year nursing student, you are invited to participate in my research. If you choose to participate, you will be asked to complete two surveys and an interview. You may take your time in responding, providing as much information as you feel comfortable providing. The questions will be about your opinions of your intercultural communication encounters with patients and your use of the website. There are no right or wrong answers. You will not be asked to share any identifying patient information and you may choose to not answer questions at any time.

If you participate in this study, you will be helping me gain a better understanding of nursing students' intercultural communication competence during interactions with Hispanic patients. My goal in the study is to take a close look at intercultural communication in provider-patient clinical interactions and how improved intercultural communication competence might lead to improved communication in such relationships.

Your participation in this research study is completely voluntary and will not impact your grade, even if you choose not to participate. Your responses and participation are strictly confidential and will only be shared with East Carolina University professors. In fact, I would like for you to think of another name to go by during the study. Please remember the name you wish to be called and use that name when completing the surveys and interview questions. All data will be protected and your identity, location and college will not be revealed. Only the research team will access the data. The findings, with anonymity of participants, will be used in the writing of the thesis and possibly presented and/or published in the future. There are no known risks to participants associated with this research. You will receive no monetary benefits or incentives for participating in this research. I appreciate your time.

**I have read this consent form and have been offered the chance to ask questions. I am providing my consent to participate in the study.**

Participant's signature \_\_\_\_\_ Date: \_\_\_\_\_

A copy of this consent form will be provided to you.

If you need to contact me, please call 252-813-9813 or email [kpd1010@gmail.com](mailto:kpd1010@gmail.com).

APPENDIX C: INTERCULTURAL COMMUNICATION COMPETENCE  
SELF-ADMINISTERED PRE-ASSESSMENT

As you know, your participation in this research study is completely voluntary and will not impact your grade, even if you choose not to participate. Your responses and participation are strictly confidential and will only be shared with East Carolina University professors. All data will be protected and your identity will not be revealed. Only the research team will access the data. The findings, with anonymity of participants, will be used in the writing of the thesis and possibly presented and/or published in the future. As a participant in this study, you are helping me gain a better understanding of nursing students' intercultural communication competence during interactions with Hispanic patients. I ask that you are thorough in your responses. Thank you for your time.

*Please complete the information below.*

Today's Date:

Your Pseudonym:

Age:

Cultural Background:

Gender:

Educational background:

Professional background:

*Please answer the following questions.*

1. What do you expect it to be like when you interact with Latino patients?
2. How would you define the perfect intercultural interaction with Latino patients?
3. What are your goals when communicating intercultural with Latino patients?
4. What do you expect from Latino patients when communicating with them?
5. Do you feel the terms are already defined for your intercultural communication with Latino patients or do you feel you are flexible when communicating with them?
6. How comfortable are you in talking with non-native English language speakers?

## APPENDIX D: INTERCULTURAL COMMUNICATION COMPETENCE SELF-ADMINISTERED POST-ASSESSMENT

Please take your time in answering these questions and provide as much information as you feel comfortable providing. The questions will be about your opinions of your intercultural communication encounters with patients and your use of the website. Please know there are no right or wrong answers. You will not be asked to share any identifying patient information and you may choose to not answer questions at any time.

Your participation in this research study is completely voluntary and will not impact your grade, even if you choose not to participate. Your responses and participation are strictly confidential and will only be shared with East Carolina University professors. All data will be protected and your identity will not be revealed. Only the research team will access the data. Findings will be used in the writing of the thesis and possibly presented and/or published in the future.

As a participant in this study, you are helping me gain a better understanding of nursing students' intercultural communication competence during interactions with Hispanic patients. I appreciate your time.

Today's Date:

Your Pseudonym:

*Please answer the following questions.*

1. What do you expect it to be like when you interact with Latino patients?
2. How would you define the perfect intercultural interaction with Latino patients?
3. What are your goals when communicating interculturally with Latino patients?
4. What do you expect from Latino patients when communicating with them?
5. Please select the option below that best describes how you feel about intercultural interactions.

I feel the terms of intercultural interactions are:

\_\_\_\_\_ Prenegotiated - You are not going to change what you say or do during an interaction based on someone else's cultural background.

\_\_\_\_\_ Partly Prenegotiated - You are on the fence and might consider altering the way you communicate to accommodate the expectations of the person from another culture.

\_\_\_\_\_ Fully Negotiable - You are going to do your best to communicate with a person of another culture the way you understand they want to be communicated with.

6. Approximately how many times have you used the website?
7. Approximately, how long did you use the website each time you accessed it?
8. How comfortable are you in talking with non-native English language speakers?
9. Was the website useful for you? How so?
10. What was most useful about the website?
11. What was least useful about the website?
12. Would you like to see anything additional included on the website?

APPENDIX E: INTERCULTURAL COMMUNICATION COMPETENCE  
SELF-ADMINISTERED PERSONAL INTERVIEW

During this interview, I will ask you three questions about your opinions of your intercultural communication encounters with patients and your use of the website. Please record your responses on your computer. There are no right or wrong answers. I will not ask you to share any identifying patient information, and you may choose to not answer questions at any time. So, let's get started. First, please fill in your pseudonym and the date of the interview.

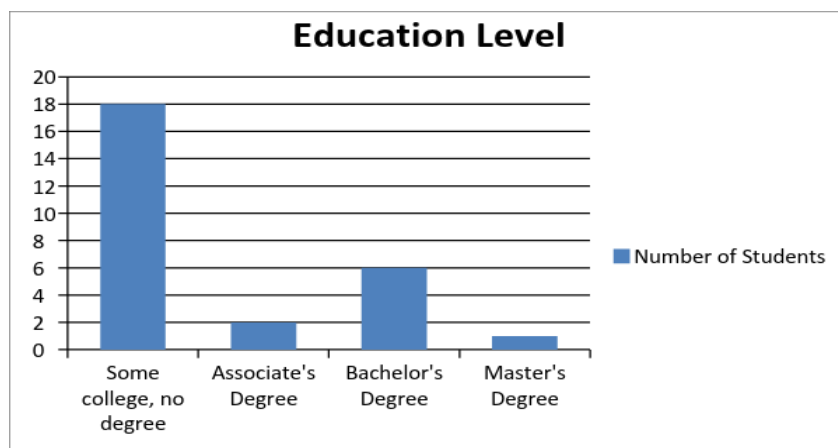
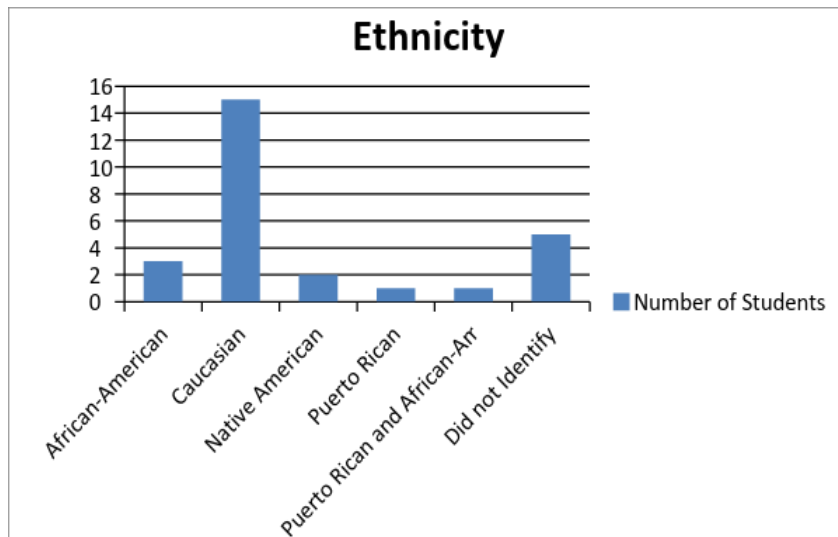
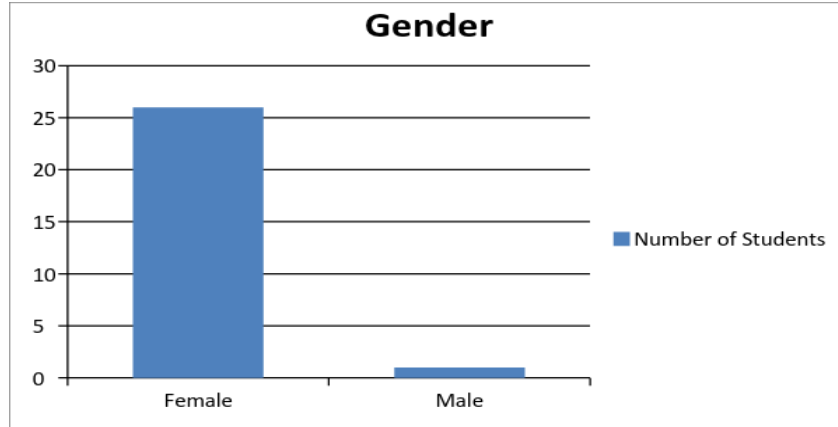
Student Pseudonym:

Date of Interview:

Now, as we go through the next three questions, please try to think about your clinical interactions. Feel free to stop and ask me questions or for clarification at any time.

1. Tell me a story about a significant intercultural experience during your clinical rotation.
2. How did your previous experiences help you with this?
3. Did the website content help you in this situation? If so, how? If not, why not?
4. Please share anything else below that you feel may benefit this research study.

## APPENDIX F: DEMOGRAPHICS



## APPENDIX G: PRE-TEST, POST-TEST AND INTERVIEW CODING

### *Pre-Test Coding*

<b>Open Coding Category</b>	<b>Definition</b>	<b>Examples</b>
Difficult	Language barrier Cultural differences	
Language Barriers	They do not know English. I do not know Spanish.	I try to understand. I do my best. I can piece together. Have some understanding.
Cultural Differences	Different preferences and beliefs	They sometimes have superstitions.
Goals & Strategies	Good Communication Learning experience Meet patient needs Build trust	Making sure they understand what I am trying to convey to them. Want to get my point across
Expectations	Good Experience Learning experience Not to know English Not to understand me Adaptation Confusion	Expect them to communicate an understanding of the situation. If they do not understand, I expect them to let me know that. I expect and hope for their body communication to be the same as my own. I expect them to let me know when they don't have a complete understanding of what is being said ...so we can get on one accord in our nurse-patient relationship." I expect the patient to be in tune with what I am saying or teaching, express understanding and ask questions about things they do not understand.
Interventions	Translator, Write English , Smile Nonverbal, communication	
Perfect Interaction	Mutual understanding Without difficulty Good communication Being from same culture Trusting relationship Comfort	Treat all races equally Dealing with a patient that is able to speak English If they spoke English Having a translator
Predefined Terms for Intercultural Communication or Flexible when communicating?	Flexible – willing to learn ways to communicate to make it easier Flexible – willing to do whatever is needed	Due to upbringing as a military child I will be flexible when communicating  I feel terms are already defined because I don't know how to communicate well with Latino patients in their language.  I feel like I want to expand my communication skills with the Latino community.  I hope that the healthcare community all together will find a way to better communicate with different cultures.
Comfort Level	Uncomfortable Comfortable Afraid of language barriers	I don't know what they are trying to say I feel like I am comfortable, I never really had to interact with a non-English speaker. Very comfortable. Again, I simply try and speak very kindly and show reverence for our language barrier and facilitate communication in any way possible.

<b>Axial Coding</b>	<b>Selective Coding</b>
Difficult, language Barriers, Cultural Differences, No knowledge of others' language	Perceived difficulty prior to interaction due to differences.
Translator needed, I don't know Spanish, they don't know English, nonverbal communication	Feel the need for language interventions. I.e) learn Spanish, they learn English, translator
Good communication needed, learning experience, adaptation, meet patient needs, build trust, mutual understanding, comfort desired, make sure they understand	Desire for good communication with mutual understanding
Uncomfortable, afraid	Negative feelings anticipated
I do my best, have some understanding, will use nonverbal communication, smile, will be kind to them, making sure they understand me, establish trust, meet patient needs, mutual understanding	Desire to meet patient needs

#### ***Post-Test Coding***

<b>Open Coding Category</b>	<b>Descriptors</b>	<b>Examples</b>
Difficult	Language barriers Website will help me Cultural differences make things more difficult Better than before Hard to communicate and get them to understand Looking forward to paying attention to nonverbal Expect the barriers to be lessened Expect latinos to keep close proximity and to use touch to convey feelings. Difficult but I will smile and avoid prolonged eye contact	Just like every other interaction with other patients. Maybe some communication problems due to language differences. i expected there to be some difficulty due to language barriers Hard to communicate and get them to understand. I expect it to be a little easier now with the website. It can be difficult to communicate because the language is so diverse. It might be hard to communicate with them, but there are tools to help facilitate communication. This will make treatment run more smoothly.
Understanding	They understand what's happening Understand more of their language Understand more nonverbal language Understand cultural difference Understand needs and wants Help them understand Express compassion Communicate and understand Provide better care to Latinos Understand what they are telling me Let them know I'm there to listen Educate them Mutual understanding Patient understands Being able to understand patient's needs	My main goal when communicating with a Latino patient is to let them know that I am there to listen and understand what they are trying to tell me. I want to be able to make them feel like they are receiving safe care and that their cultural differences are being considered. My goal is to educate them on what they need, and let them know I care, and I want them to be comfortable and build trust with me. To make sure that they feel understood and that I am being proactive to meeting their requests. To apply nursing techniques according to their culture and not mine. Give holistic care to the best of my knowledge, identify and overcome barriers of communication,



	Having translator	obtain the information needed through non verbal communication and translators. To have clear understanding of the problem they are facing, and being able to explain the treatment so the can consent with understanding.
Goals	For them to understand what I'm telling them Confusion Ability to express understanding Nervousness Smaller area of personal space To learn about their culture To know what they expect For them to be open and learn For them to try to understand Speech barriers	communicated in a way that everything is understood when being a positive advocate for patients, it is not possible for everyone to be able to learn and speak a foreign language; it is imperative in my humble opinion that enough personnel are able to speak foreign languages and be available for translations to assist in patient care. I personally will be taking a foreign language class to assist me in communication with patients in my geographical region. My goal is to effectively and express compassion and understanding. My main goal when communicating with a Latino patient is to let them know that I am there to listen and understand what they are trying to tell me. I want to be able to make them feel like they are receiving safe care and that their cultural differences are being considered. My goals are now to be able to communicate, understand, and provide better care with the Latino patients. To effectively communicate and convey all needed information with the patient. My goal is to educate them on what they need, and let them know I care, and I want them to be comfortable and build trust with me. To provide care to treat the patient mentally and physically. My goal is to gather important information needed to perform my nursing duties for the client.
Positive Descriptors	Confident Able to understand Learning experience Resources help	

<b>Axial Coding</b>	<b>Selective Coding</b>
Difficult, Language barriers, Cultural differences make things more difficult, Hard to communicate and get them to understand, desire for mutual understanding	Anticipated difficulty
Learning experience, Website will help me, Better than before, Looking forward to it, Expect the barriers to be lessened, Expect Latinos to keep close proximity and to use touch to convey feelings.	Perceived improvement with new cultural knowledge

I can communicate with compassion, I will smile and avoid prolonged eye contact, paying attention to nonverbal, know what they expect, Understand more nonverbal language, Understand cultural difference, Understand needs and wants, Let them know I'm there to listen, Educate them	How to improve communication based on what nurses learned
For them to be open and learn For them to try to understand For them to understand what I'm telling them Confusion Ability to express understanding Nervousness	Othering
Hope to meet patient's personal needs Want to understand cultural beliefs A learning experience Patient feels comfortable with me They understand English or there is a translator With medical interpreter present	Concern for patient feelings and needs

### *Interview Coding*

<b>Open Coding Category</b>	<b>Descriptors</b>	<b>Examples</b>
Patient Characteristics	Very little English Very nice Open to learning, sharing Family with her Expressed understanding and concern Required a translator	"I had a few pts that didn't understand what was being said. It and all they could do is giggle."
Translator	Teenage son explained mother's vaginal bleeding during ectopic pregnancy MARTI Interpreter Student spoke a little Spanish EMS used note cards to assist in communication	"We also used Marti, which is a computer with a translator. I find this to be impersonal. I talked with the patient in Spanish as much as possible. I held her hand and comforted her through procedures. Before she was told her diagnosis, she told me that she was going to name her baby after me if it was a girl. unfortunately, the patient did not end up with a child. At the end of her visit she cried and thanked me for my compassion. This made me want to become more fluent in Spanish. I would like to be able to fully communicate in Spanish with my patients without using Marti."
Condition Being Treated	Ectopic Pregnancy Postpartum Interview Active Labor Well baby check/immunizations Motor Vehicle Crash/On Scene	

Website	Would have been helpful if I had intercultural interaction It helped Provided confidence Made me comfortable Helped me understand them		
Most helpful website info.	Gave good tips Let me know how to react How to adapt my care Hispanic women's preferences Translator etiquette Migrant cultural information Nonverbals Cultural differences		"It {the website} has also changed my perception on talking to clients of different cultures."
Additional Comments	Provides very good base knowledge on how to help Latino patients Good to look back on as a reference Good facts and info More information needed about other cultures		"I feel that this research study helped me have a better attitude toward intercultural interactions."

#### Axial Coding

#### Selective Coding

Translator, teenage son explained mother's vaginal bleeding/ectopic pregnancy, MARTI, Interpreter, Students spoke a little Spanish, EMS use of notecards	Other's responsibility to know the language and/or for verbal communication
Website and cultural information, Would have been helpful if I had intercultural interaction, It helped, Provided confidence, Made me comfortable, Helped me understand them, Provides very good base knowledge on how to help Latino patients, Good to look back on as a reference, Good facts and info, More information needed about other cultures	Perceived comfort following exposure to website with cultural information

## APPENDIX H: WEBSITE

# Intercultural Communication in Nursing

### Welcome Nursing Students!

As nursing students, the way you communicate with patients during clinical rotations can directly impact the care your patients receive. Effective communication allows nurses and patients to interact exchanging useful information in the healthcare setting. When considered in an intercultural context, verbal communication and nonverbal communication can be challenging. Intercultural barriers that can exist in a healthcare setting can also make provider-patient communication extremely difficult.

As you work at the local health department and hospital during your summer clinicals, you will provide care for many Spanish speaking female labor and delivery patients due to the large amount of migrant and seasonal farm workers (MSFWs) arriving locally for summer work. The tools found on this website will be helpful as you communicate with patients who do not speak, write or read English.



#### The goals of this site are:

- To help identify barriers in communication between English-speaking student nurses and Spanish-speaking patients
- To provide tools for student nurses to use when communicating with Spanish-speaking patients
- To demonstrate ways to communicate effectively with different cultures in a healthcare setting in general
- To show how Latino patients react and outcomes can be influenced by nurse nonverbal communication during patient care
- To provide the information about the ways different audiences react to nonverbal cues
- To inform nursing students of how they can make a difference in patient care through the use of appropriate nonverbal communication when treating Latino patients

#### After using this site, community college nursing students should be able to:

- Identify ways to better communicate with patients from different cultures.
- Communicate relevant information during labor and delivery to Spanish speaking patients.
- Identify and overcome barriers and communication challenges when communicating with people of different cultures.
- Gain an understanding that different audiences communicate differently nonverbally
- Understand how to build a rapport with a Latino patient or audience
- Better communicate with patients through nonverbal communication
- Understand that what works for the sender is not always what works best for the receiver

Hopefully, as a result of utilizing these tools, you will experience greater patient satisfaction and improved outcomes.

#### Search This Blog

#### • Home

- About this Site
- Migrant and Seasonal Farm Workers
- Learning Cultural Competence
- Verbal Communication and Translators
- Patient History Translation
- Labor Terms Translated
- Spanish Pronunciations
- Nonverbal Communication Overview
- Types of Nonverbal Communication
- Nonverbal Communication Quiz
- References

#### Sites of Interest

- Video Interpreters Save Lives
- Intercultural Communication Competence in Healthcare
- Spanish Dict Online Translator
- Think Cultural Health
- Tips for Working with Translators
- U.S. Department of Health and Human Services Office of Minority Health
- The Provider's Guide to Quality and Culture
- National Center for Cultural Competence
- Diversity Rx - Improving Health Care for a Diverse World
- Google Translate
- Office of Minority Health and Health Disparities
- National Association of Nurses
- Labor and Delivery Staff Nurse
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- American Nurses Association
- Transcultural Nursing Society

#### Videos About Intercultural Communication

- Gispegula Health Literacy - Part 1
- Intercultural Competence
- Dr. Hiranthi Jayaweera on Health Issues for Migrant Women

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APPENDIX I: STATE COMMUNITY COLLEGE SYSTEM  
REQUIRED CURRICULUM FOR CULTURAL TRAINING FOR NURSES

**Diversity**

**Unit VII - Module A**

**Domain:** Individual

<b>Concept</b>	<b>Definition</b>	<b>Exemplar</b>
Diversity	Refers to the individual's variations both to innate and acquired characteristics such as: age, gender, race, abilities, individual life experiences, and sexual orientation.	Vulnerable populations Age Gender Race Abilities Individual life experiences Sexual orientation

**Learning Outcomes**

Upon completion of this module the student will:

1. Discuss the concept of diversity as it applies to vulnerable populations, age, gender, race, abilities, individual life experiences, and sexual orientation.
2. Identify the impact of diversity on a client's health beliefs and health values.
3. Describe the influence of diversity on a client's utilization of healthcare services.
4. Discuss appropriate assessment questions to identify needs of diverse clients to promote safe nursing care.
5. Identify nursing interventions that will ensure client-centered competent care for diverse population.
6. Identify interdisciplinary team members that may enhance healthcare for individuals from diverse populations.

**Learning Resources**

**Textbook Readings** Treas & Wilkinso, pp: 318-320  
ATI Community Health Review Module, Chapter 4

**Websites**

- <http://www.nhchc.org/>
- <http://www.genderandhealth.ca/en/modules/sexandsexuality/gss-objectives.jsp>
- [http://www.urban.org/health\\_policy/vulnerable\\_populations/index.cfm](http://www.urban.org/health_policy/vulnerable_populations/index.cfm)

## Culture

### Unit VII - Module B

**Domain:** Individual

Concept	Definition	Exemplar
Culture	Comparative study and analysis of different cultures and subcultures in the world with respect to their cultural care, health beliefs, and health practices with the goal of providing healthcare within the context of the client's culture.	Multiculturalism Values Beliefs Cultural Competency

### Learning Outcomes

Upon completion of this module the student will:

1. Discuss the concept of culture as it relates to healthcare practices.
2. Describe the impact of cultural values on the utilization of healthcare services.
3. Identify factors related to communication with culturally diverse clients.
4. Develop appropriate assessment questions to identify cultural needs to promote client-centered care.
5. Identify nursing interventions which will promote culturally sensitive healthcare.
6. Describe cultural competence as it relates to nursing and healthcare.
7. Identify interdisciplinary team members that may enhance culturally sensitive healthcare.

### Learning Resources

**Textbook Readings** Treas & Wilkinso, pp: 315-336  
ATI Fundamentals Review Module, Chapter 35

#### Websites

- <http://www.culturediversity.org/>
- <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1924616>

### Learning Activities

- Values Clarification Activity: Escape From Primavera Island
- <http://adn-cip.waketech.edu/modules/NUR212/NUR212EthicsClarExercise.pdf>

## Spirituality

### Unit VII - Module C

**Domain:** Individual

Concept	Definition	Exemplar
Spirituality	An experience or feeling of being alive, purposeful, and fulfilled with the ability to make sense of life circumstances, beliefs about the universe, feelings of transcendence, joy, hopefulness, and love.	Spiritual health Spiritual well-being Spirituality and religion Higher consciousness Morality Spiritual distress

### Learning Outcomes

Upon completion of this module the student will:

1. Describe the spiritual development of a client across the lifespan.
2. Compare and contrast the difference between spirituality and religion.
3. Describe the characteristics of spirituality, morality, and spiritual distress.
4. Describe the connection between health and spiritual well-being.
5. Identify data to collect to determine a client's spiritual or religious preferences.
6. Describe the influence of spiritual and religious beliefs on healthcare practices.
7. Describe how spirituality is influenced by a client's culture.
8. Develop a nursing care plan based on best practices for a client to maintain or restore spiritual well-being.
9. Describe interdisciplinary care for clients with spirituality needs.

### Learning Resources

**Textbook Readings** Treas & Wilkinso, pp: 337-355  
ATI Fundamentals Review Module, Chapter 35

#### Websites

- <http://familydoctor.org/online/famdocen/home/articles/650.html>
- [http://findarticles.com/p/articles/mi\\_m0FSZ/is\\_3\\_29/ai\\_n18615868/](http://findarticles.com/p/articles/mi_m0FSZ/is_3_29/ai_n18615868/)
- [http://www.bravewell.org/integrative\\_medicine/philosophical\\_foundation/spirituality\\_and\\_healthcare/](http://www.bravewell.org/integrative_medicine/philosophical_foundation/spirituality_and_healthcare/)

## APPENDIX J: IRB APPROVAL



**EAST CAROLINA UNIVERSITY**  
**University & Medical Center Institutional Review Board Office**  
4N-70 Brody Medical Sciences Building · Mail Stop 682  
600 Moye Boulevard · Greenville, NC 27834

Office **252-744-2914** · Fax **252-744-2284** · [www.ecu.edu/irb](http://www.ecu.edu/irb)

Notification of Initial Approval: Expedited

From: Social/Behavioral IRB  
To: [Kelley Deal](#)  
CC: [Rebecca Dumlao](#)  
Date: 5/12/2014  
Re: [UMCIRB 14-000757](#)  
Breaking Barriers in Intercultural Patient-Provider Relationships

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) is for the period of 5/12/2014 to 5/11/2015. The research study is eligible for review under expedited category #7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
4_2_14Proposal.docx	Study Protocol or Grant Application
consentrev.docx	Consent Forms
Scripts.docx	Surveys and Questionnaires
Scripts.docx	Interview/Focus Group Scripts/Questions

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

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IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418  
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

Study.PI Name:  
Study.Co-Investigators: